



# FACE Program Fact Sheet

## Fatality Assessment and Control Evaluation

Department of Health and Family Services \* Division of Public Health  
Bureau of Occupational Health \* 1 W. Wilson St. \* PO Box 2659  
Madison, WI 53701-2659 \* (608) 266-7298

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## SUPERVISOR CRUSHED AND KILLED BY MOVING PARTS OF INJECTION MOLDING MACHINE

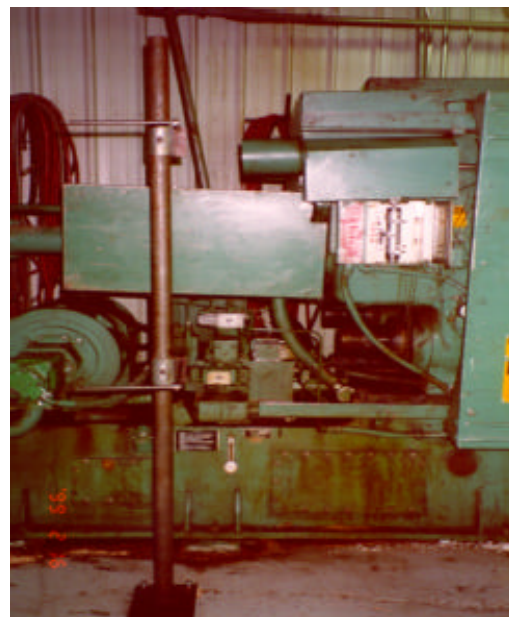
### BACKGROUND

The Wisconsin Fatality Assessment and Control Evaluation (FACE) Program received reports of 91 fatal occupational injuries during 1999. Four of those occurred when workers were crushed between moving parts of machines as the machines were being maintained or repaired.

This fact sheet describes one incident and requests that occupational safety professionals and employers who use injection molding equipment bring the following recommendations to the attention of injection molding operators and others who work around stationary equipment with moving parts.

### THE INCIDENT

A 38-year-old supervisor died when his head was crushed between moving parts of an injection molding machine. About two weeks before the incident, a machine guard had been removed from the molding machine in preparation for a maintenance worker. At the time of the incident, the victim and a co-worker were examining the machine to determine the location of a hydraulic fluid leak. The molding machine was operating while the victim and co-worker peered into it so they could see the location of the leaks with the hydraulic hoses under pressure. The victim was bending forward into the back of the machine, with his head positioned next to a fixed metal bracket. The machine cycled automatically, causing a metal tie bar to move back and pinch his head against the bracket with about 500 pounds of pressure.



This photo was taken after the machine guards were replaced.

### RECOMMENDATIONS

Employers who use injection molding equipment should:

- maintain guards in place over machine pinch points when machines are operating.
- develop and enforce specific lockout/ tagout procedures for injection molding machines.

**The Wisconsin Department of Health and Family Services, in agreement with the National Institute for Occupational Safety and Health (NIOSH) conducts research on occupational fatalities. The Fatality Assessment and Control Evaluation (FACE) Program focuses on identifying factors that increase the risk of work-related fatal injuries. The Wisconsin FACE Program helps in the development and use of improved safety measures for preventing fatal work injuries.**

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# **PLEASE POST**

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**FACE information is produced and distributed to provide current, relevant education on methods to prevent severe work-related injuries.**

**If you have comments or questions, please call the FACE Project at 608/266-7298, or write:**

**FACE Program  
WI Department of Health and Family Services  
Division of Public Health  
P.O. Box 2659  
Madison WI 53701-2659**